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3/10/09
BILL NO. HB403

Great Falls Clinic, LLP

P. O. Box 5012 · 1400 29th Street South
Great Falls, Montana 59405
(406) 454-2171

Initial Evaluation

NAME: PRYOR, DANIEL GFC: 487-055-6
DATE: 3/31/2008 9:00:00 AM Session #1

"INITIAL INTERVIEW NOTE"

Time Spent: 95 minutes (90801)
Place of Service: Outpatient - Great Falls Clinic
Present Medication: Focalin 15 mg (tapering dosage); Strattera 25 mg q.a.m. (titrating dose); Zantac q.d.
Physicians Involved: Catherine M. White, MD (MAFB) / Christian Smith, MD (MAFB)
Diagnoses:

TREATMENT RECORD:

Daniel Pryor is an eight-year four-month-old second-grade student at Power elementary school who comes in upon the referral of his primary care physician/pediatrician, Dr. Cathy White, for evaluation of possible developmental dyslexia. Daniel is accompanied by his paternal grandmother and legal guardian, Norma Carson. The grandparents have custody based on a court order, dated August 31, 2005, from the ninth judicial district Teton County court and the Honorable Judge Marc Buyske, district court judge. With that as simple background, Daniel comes in today for initial joint interview prior to evaluation.

The grandmother says that Daniel's occupational therapist, Amy Knowles, had recommended getting this young man evaluated for the possibility of developmental dyslexia, since he seems to have letter and number reversals. His grandmother was kind enough to bring in some of his work samples for my review in that regard. She also notes that he has a tendency to not only write letters and numbers backwards, but he puts in and leaves out certain words when he is either reading or writing information. She does note that she wonders about developmental dyslexia "since the grandmother has significant developmental dyslexia and she knows it runs in the family". With that as simple background, again I do see Daniel today. His grandmother also notes that this young man has occupational therapy about one time every two weeks, has physical therapy two times a week, sees Mary Quint, a local social worker, once or twice a week depending on what he needs, and then sees either Dr. Smith or Dr. Green about one time per month for medicine management. She notes "he has ADHD, oppositional-defiant disorder, and posttraumatic stress disorder, as well as 'an unusual disorder in which he chews on everything' (referencing pica)". She also notes he has peptic ulcer disease.

Daniel himself tells me that he has the most difficulty with letter reversals of "b" and "d". He said back in years past he had trouble with "p" and "q". He sometimes will write "s" backwards. For numbers, he says "5" and "2" are the hardest, but his grandmother believes he still has trouble with the number "9".

Daniel Pryor is an 8-year 4-month-old male who lives with his paternal grandparents, Norma and Larry Carson. They have had him essentially for most of his life, probably 7.5 years. Again,

they have legal custody of him based on this court order as referenced.

Biological family history shows that his biological father was Shawn (age 26, deceased three-and-a-half years ago due to a self-inflicted injury). The biological mother is Jennifer (age 28). He does not have current contact with Jennifer, although apparently his mother is moving again to try to get custody of this young man. He does have a half-sister from his father's other girlfriend, Jessica. He has two half-sisters from his mother's previous relationships. He does not have any contact with those half-sisters on either side.

For stressful situations, the abandonment of Daniel by his parents is noted. His father passing away three-and-a-half years ago is noted. His grandmother notes that Daniel's mother tried to abduct him as a stressful event. In 2005 Department of Public Health and Human Services (DPHHS) "tried to abduct Daniel also". Apparently as his grandmother says, they went to school, his mother apparently claimed that she had custody, and DPHHS did not check that out and then wanted to try and get Daniel. Therefore, they see that as all a significant stress for this young boy. More remote history shows an abusive and neglectful trauma history for this young man, which has been alleged according to the grandparents, and the need for legal guardianship.

Extended family history shows there is no family history, maternally or paternally, of genetic disorders, tics, Tourette's, alcoholism nor substance dependency. For learning disability, the paternal grandmother has developmental deep dyslexia. Daniel's father was apparently born three months premature, suffered with ADHD, had febrile seizures, and the possibility of bipolar disorder, although that apparently was not formally diagnosed. For bipolar disorder, there is a question about whether the biological mother has bipolar disorder. I am not certain after talking with the grandmother whether that was ever diagnosed. Bipolar disorder apparently had been diagnosed in the paternal grandmother, although she says she does not believe that diagnosis anymore, nor has she been treated for either depression or mood instability. The paternal great-grandmother apparently had bipolar disorder as reported by Norma. For schizophrenia, there apparently was a paternal great-uncle as well as a paternal great-great-grandfather who were diagnosed with schizophrenic or psychotic disorder. For mental retardation, a paternal great-great-uncle was diagnosed with mental retardation. A paternal uncle apparently had febrile seizures, but also had VP shunt and was three-and-a-half months premature and also had a history of ADHD as well as depression. For other seizure disorders, Daniel's biological father apparently had febrile seizures when he was younger. For anxiety disorders, the grandmother, Norma, says that it is extensive on the paternal side of the family in the father, paternal grandmother, paternal aunts, and multiple other paternal relatives. For thyroid disorder, the paternal great-great-grandmother had unspecified thyroid disorder. Daniel is right-handed, but his father, paternal grandfather, and paternal great-uncle all were left-handed. All of this family history kindly provided to me by Norma.

For behavioral issues at home, Daniel is reportedly a "pretty good kid". He apparently has some difficulty with listening and with not cleaning his room or doing his chores without specific direction and prompting and followup.

School history shows that he is in the second grade at Power schools where he does fairly well academically. He does have some supplemental assistance in Title 1 or Chapter 1 reading services. He has that on a daily or twice-daily basis for half-an-hour at a time. He has had these services in Title 1 or Chapter 1 since kindergarten on. He also gets tutoring 30 minutes three times per week before school in reading and with his homework. That seems to be helpful for both of these services. He has gone to Power schools from kindergarten on. He did not do

preschool. He has never been retained in grade. He was evaluated by the school psychologist last year and it was found that he had some problems, but he would not qualify for other assistance. His grandmother notes that she and other therapists were not impressed with that evaluation, and therefore they wanted further evaluation of this young man. There is no active individual education plan (IEP) on this young man. For actual academic abilities, he notes that he has some difficulty with reading rate or fluency. He has clear trouble with reading recognition, decoding and sight word vocabulary. He has some trouble with reading comprehension and reading retention. For spelling, his grandmother says that she has a hard time judging that because of her developmental dyslexia. Therefore, we will have to look at that through evaluation. His handwriting is considered to be somewhat messy. Again, he does have letter and number reversals as noted. An area of strength for this young man is the area of arithmetic or mathematics. Apparently he does well in that regard unless it is "a story problem that requires reading". For behavioral issues in school, he notes with his current medicines he does better with attention, concentration and focus. He has real trouble without his medicine in that regard, as well as having difficulty with talk outs and out of seat behavior. He apparently is a more reluctant worker. He does acknowledge "I don't want to do my work, but people make me do it".

Medical history shows that he is in good general health for the most part, and followed by Dr. Cathy White for primary care purposes. He is currently seeing Dr. Christian Smith about one time per month, and there is a tapering crossover design of tapering Focalin with titrating Strattera. Strattera was started about a month ago. They have not seen any therapeutic effect in that medicine so far, but they have not seen any side effects or problems. His grandmother was unaware of whether they were going to taper the Focalin to discontinuation or just taper it to this current dose level. In addition to Focalin and Strattera, he does take Zantac for peptic ulcer disease. He has no over-the-counter medicines, nor any herbal products or remedies other than vitamins. His appetite is described as "a real small eater, and always been that way". It has been somewhat changed with medicine, but again he was never a big eater to start with. This is a 40-pound (18.2 kg) male. Sleep pattern is described as troublesome. He apparently has always slept in his paternal grandparents' bed. He has difficulty with initial insomnia, with estimated sleep latency between one to one-and-a-half hours. He also has some middle insomnia or frequent awakening. It was hard to ascertain from either him or his grandmother whether he can return to sleep fairly quickly. He does have some nightmares, but those are reported to be getting better. He does not have early morning awakening nor somnambulism. He has always talked in his sleep, but that seems to have escalated in the last two to three years. He is up fairly easily in the morning. For childhood illnesses, he had chronic otitis media treated initially with antibiotics and then subsequently with myringotomy with tubes at two-and-a-half years of age. He has peptic ulcer disease reportedly. He did have amblyopia that did require eye patching when he was younger. That is in his left eye. He has no history of head injuries or head traumas, high fevers producing residual or sequelae, nor any accidental poisoning or toxic exposures or allergies. For surgeries, he again had myringotomy with tubes at two-and-a-half years of age. He had three lymph nodes removed from his left neck according to his grandmother. Those apparently were benign. He tolerated general anesthetic well for both of those surgeries.

For psychological history, he does see Mary Quint, a local social worker, once to twice a week depending on his needs. He sees Dr. Christian Smith one time per month as a child-and-adolescent psychiatrist. Previously he also saw Dr. Green in Bozeman as a child-and-adolescent psychiatrist. In addition, he is followed by Grant Poor, physical therapist, Amy Knowles, occupational therapist, and does see Dr. Mindy Sterner for his eyes, and also has consulted a dietitian, Carol at Malmstrom Air Force Base, for his small appetite and slender

build.

More remote medical history shows that he was a full-term baby, reportedly somewhere between 7 to 8 pounds according to the grandmother. This was a cesarean section delivery. Tobacco utilization was positive during the mother's pregnancy. The grandmother reports that Daniel's mother had maybe an occasional glass of wine, but not much. He was a healthy neonate. Developmental milestones were reached within normal limits, although he reportedly was quite colicky, and has some difficulty requiring occupational and physical therapy.

For interest pattern, this young boy says "I used to like to play with the puppies we had, but we had to sell them". He likes to play with his friends, play on the swing set, or play PlayStation 2. He does love to ride horses, and they live on the edge of Power and they do have horses. He also likes to swim in the summer.

For affective status, he notes "I'm happy to be me". He denies any real dysphoric mood or depression. He does acknowledge he has the diagnosis of posttraumatic stress disorder (PTSD), and says "I feel an emptiness". He then goes on to report some discussion about "the science of science". That comment actually did not seem to make much sense in its context. Nonetheless, he does acknowledge some feelings of emptiness or aloneness. I did encourage him to talk with his therapist about that. He does acknowledge he worries about a number of things. He also has some specified phobias such as lightning, tornadoes, being kidnapped, monsters, fear of the dark and fear of the basement. He needs either the cat or dog to be with him while taking a shower or a bath. He will not go down to the basement without some assistance or without one of the pets.

MENTAL STATUS EXAMINATION:

On structured clinical interview and mental status examination, Daniel Pryor is an 8-year 4-month-old Caucasian male who sports light brown hair, light colored eyes. and does present with a fair complexion with faint freckles across the bridge of his nose. He does appear wearing glasses. He appears with no other dysmorphic characteristics. He is of somewhat shorter stature and very slender build. He was casually attired, and was neat, clean and kempt for the appointment. Behaviorally he is noted to be verbal and fluent, and does have some mild disarticulation for certain speech sounds. He is cordial, cooperative and pleasant. He maintains fairly good eye contact with this examiner. Affectively he comes across as "a serious and quiet kind of kid". He does have a history of anxiety, increased worry, a number of specified phobias, and a history suggestive of posttraumatic stress disorder. His appetite and sleep are as described above. Perceptually, there is no indication of any visual, auditory or olfactory misperceptions, and he is fully oriented. Thought processes reflect average intellectual ability. There is a question of attention and concentration, and we will evaluate that further on current medicines. No obvious signs of organic brain syndrome or psychotic thought process is noted. Thought processes did appear to be logical, rational, well paced to slightly slowed, but relatively intact.

DIAGNOSTIC IMPRESSION:
Axis I:

1. ADHD, combined (314.01)
2. Oppositional-defiant disorder of childhood (313.81)
3. Posttraumatic stress disorder, chronic or delayed, per history (309.81)
4. Numerous specified phobias (lightning, thunder, dark, kidnapping, monsters, fear of the basement; 300.29)

5. Life circumstance problems.
Axis II:
1. ?? R/O Developmental dyslexia with dysgraphia ?? (needing evaluation)
2. Phonological disorder (disarticulation for certain speech sounds; 315.39)
Axis III: MD diagnoses as listed above.
Axis IV: Multiple significant stressors.
Axis V: GAF-C: 55

We will see Daniel back for comprehensive evaluation to look at his reading and spelling abilities and to look at the possibility of developmental dyslexia with dysgraphia. Again, there is a family history of such. The paternal grandmother and legal guardian, Norma Carson, is eminently aware that we will see this young man for evaluation only, but not for ongoing care.

This young man is served by TriCare Health Insurance, as well as ASI Supply Insurance. TriCare had recently informed the Clinic that if one of their pediatric patients was referred by a pediatrician they would waive preauthorization evaluation paperwork. Therefore, we will provide this evaluation at the request of his pediatrician, Dr. Cathy White, without completing paperwork as we have been instructed.

His grandmother was informed that we will need a number of different sessions to get this evaluation concluded. Therefore, that was scheduled.

His grandmother did sign a release form so we can keep his physicians on Base, Cathy White MD, as well as Christian Smith, MD, both closely informed of our thoughts and ideas, which we surely will do. In addition, she signed a release for Mary Quint, LCSW, so we can keep her informed of our thoughts and ideas, which we surely will do.

PLAN: See back for evaluation as noted above.

Thomas J. Krajacich, PhD, ABMPP
D: 3/31/2008
T: 4/2/2008 - dmc Job #: 1056167

cc1: Catherine M. White, MD
Malmstrom Air Force Base
cc2: Christian Smith, MD
Malmstrom Air Force Base
cc3: Triwest
1-866-867-7926
cc4: Mary L. Quint, LCSW
1601 Second Ave North, Suite 200
Great Falls MT 59401

Cathy: Thanks for the kind referral. We will be back to you with the results shortly. Thanks again for the kind referral. Tom

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CHILD PSYCHIATRY EVALUATION

Date of Evaluation: 05/17/2007

Referral Source: The patient's grandparents and Dr. Bruce Smith, psychiatrist in Helena.
Identifying Data: Dan is a 7-year-old white male, currently in the first grade at the Power School in Power, Montana. I saw him today with his grandmother for 90 minutes.
History: Dan and his grandmother presents to my clinic with a chief complaint of anxiety affecting his sleep and several other areas as will be detailed below. In addition, he has a previously diagnosed problem with ADHD characterized by poor concentration of task behavior, speaking out in loud voice, and having scattered thoughts and behavior. We explored his sleep history, it turns out that he goes to bed with quite a bit of prodding from his grandmother between 7 and 8 p.m. He does not fall asleep until 11 or 12 p.m. if he takes his melatonin. If he does not take his melatonin, he can be awake literally all night without significant fatigue the next day. Assuming he gets to sleep around 11 or 12, he typically will wake up at 2 to 3 in the morning and crawl into bed with his grandparents and goes promptly to sleep. Grandmother says he seems more comfortable close by and this is true in the daytime as well as at nighttime during sleep. This is a stable pattern and in other words does not fluctuate much from one week to the next and has been present for at least the last 2 or 3 years. His ADHD symptoms have been present lifelong and do respond favorably to his current medication. His anxiety issues seem to relate largely to the death of his father when he was 4 years old. His father died in September 2004 from a gunshot wound. Dan tells me that he thinks this was an accident, says his father was "trying to shoot the refrigerator." Grandma says that dad had purchased a firearm just 20 to 30 minutes prior. She found it very difficult to talk about this and indicated that she did not want to talk about the details of what happened in front of Dan, and so, I am not sure if the death was accidental or not. Dan tells me that he misses his dad and it bothers him a lot and that since then he has had a great deal of difficulty with anxious symptoms. We reviewed the diagnostic criteria for posttraumatic stress disorder. He does meet criteria A, particularly the death of his father. There are also some issues with his mother as will be detailed later. Category B symptoms, he does have recurrent intrusive bad thoughts and memories of his father dying, and there is quite a bit of repetitive play some of it involving shooting and a lot of it involving killing and monsters attacking each other and so forth. He has had bad dreams, both related to the death of his father and frightening dreams about monsters killing him and his dad defending him. He also experiences a lot of distress when he is exposed to reminders of what happened. He does manifest avoidance symptoms. He tries to avoid talking about the death of his dad. He does avoid contact with his mother as again will be detailed below, and he had a decrease in his ability to interact socially with other people for several months after the death of his father and was less affectionate. Increased arousal is definitely a problem. He has difficulty falling and staying asleep. He has irritability and outbursts of anger. He has difficulty concentrating, increased since this event. He is hypervigilant. He does not seem to have an exaggerated startled response. The central issue with his mother as Dan states is "I am afraid she is going to kidnap me." He reports that she tried to take him in October 2004. She came to his daycare and the daycare provider called the police. He recalls the police coming "flashing lights" and then he says "she got tired of it and decided to leave." He was referring to his mother. Grandmother reports that there have been long-term problems with Dan, between Dan and his mother. She says that there is evidence that she is not capable of child rearing and taking good care of kids. She reports that the children were removed in 2002 by DPHHS because of abuse. She indicates that photographs were taken suggesting that it was physical abuse. Again, the children were removed in August 2006 from mother and then a couple of weeks later taken from school, to be put into foster care. Now, grandmother and her husband have custody of Dan, but mother still has parental rights, and as recently as October 2006, the judge refused to terminate mother's parental rights. Last face-to-face contact between Dan and his mother was on November 3, 2006. Since then, there has been the occasional letter from her and when a letter arrives, she notes that Dan starts soiling and wetting in the daytime.
Current Medications: Focalin 5 mg p.o. b.i.d., this is prescribed by Dr. White, a physician at the Malmstrom Air Force Base in Great Falls. Apparently, Dr. White had referred Dan for further evaluation of his anxiety to Dr. Smith and Dr. Smith referred Dan to me because of his young age. I have a note from Dr. White indicating that she was planning to switch the Focalin to a XR capsule 10 mg each morning. Melatonin 4.8 mg q.h.s.
Past Psychiatric History: Dan has no history of substance use. There is a history of physical abuse. I do not know if there is a history of sexual abuse, and there is a history of neglectful parenting and the emotional trauma of loss of his father and fear of being kidnapped by his mother.
Past Medications: He did take Adderall in the past. This medicine was also helpful with ADHD symptoms, but caused weight loss and was replaced with Focalin. He is eating better with Focalin and it also is helpful for his ADHD symptoms. Grandmother reports that there was a trial of clonidine in the past, she does not remember the dose or the

BRIDGER CHILD AND ADOLESCENT PSYCHIATRY, P.C.
931 Highland Blvd., Suite 3340
Bozeman, MT 59715
406-586-9735 Fax-4713

NAME: Dan Pryor
DOB: 11/01/1999

mw 5/23/07

duration of treatment, but does believe that it was helpful for helping him get to sleep at nighttime. She also indicates that clonidine and melatonin were used simultaneously for a while.
Oral Counseling: Currently, Dan works with Mary Quint, counselor in Great Falls, Montana. He also works with Joy Miles, a behavioral specialist, who does some in-home therapy, and she is based in Great Falls. Grandmother indicates that she is also seeing Joy for her personal counseling.
Development/Social History: Per grandmother's report, pregnancy was 9 months in duration. She does not know whether the birth mother took medications or not. She reports that there was cigarette, alcohol, or other drug use, but does not give details. She reports that the mother wanted the pregnancy, but she is not sure about father. No other complications are reported. It was a cesarean delivery, no details, 2 days in the hospital for mother and infant. No colic irritability in infancy is reported. He was most closely attached to mother and to grandmother during infancy, and there were caretaker changes in the first 4 years of life. Grandmother really does not report milestones except to say that the walking was delayed until 2 years of age, first words were spoken at 1 year and understanding language and verbal request from parents at 2 years. Other development milestones not reported.
Current Family Constellation: Dan lives with his paternal grandmother and step-grandfather. His mother is alive, living in Great Falls. She is 26 or 27; father is deceased for the past 3 years. He has a half sister, age 3, from another relationship that mother had, and he has a half sister, age 3, from father's other relationship.
Medical History: Grandmother reports no medication or other allergies, says he was hospitalized for surgery and two sets of tubes placed in his ears, dates not specified, and notes that he had fevers associated with ear infections, problems with bladder control particularly stress related as noted above, same with bowel problems, and troubles with weight gains, particularly on Adderall. Vision problems, he wears glasses and is nearsighted. No neurologic history. No asthma or heart trouble. No snoring. Tonsils and adenoids are intact.
Family Psych and Medical History: Grandmother reports that Dan's father had ADHD and that his mother may have bipolar disorder, she has heard that from a family member. She apparently had or still has substance abuse problems. There is also a family history of ADHD in paternal grandfather. She reports "he could not hold the job." There is also a family history of "manic depression" in paternal grandmother, Dan's father. In the case of father, grandmother reports that he would have spells where he was "up for 2 or 3 days, talking too much, and he would have difficulty with self control." In addition, maternal great uncle has manic depression and characterized also by prolonged periods of insomnia, excessive talking, hallucination, paranoia, and takes psychotropic medications, but she is not sure which ones. Grandmother says that she has prolonged grief and is very upset about loss of her son. She gets jittery and hyperemotional and has difficulty talking whenever the subject comes up. She tends to avoid talking about and she says she would not be surprised if she also has PTSD.
Mental Status Exam: Dan is alert, cooperative, and well groomed. No tics or abnormal movements are noted. He loves wearing eyeglasses. He does appear small for his age. He was a little bit timid at first, but he warmed up fairly quickly. His place is definitely notable for aggressive themes running throughout, for example, dinosaurs fighting and killing each other and his last act in my office today was to build a model of the twin towers in New York City, and he showed me where the airplanes hit the towers. His speech was well articulated with a normal rate and tone. His mood appeared mildly anxious, but otherwise euthymic. His affect was appropriate to his mood. His thoughts were marked by recurrent themes of danger, disaster, conflict, and aggression. His thoughts were also marked by a lot of factual knowledge, particularly dinosaurs and science topics. There was no evidence of racing thoughts, loose associations, and flight of ideas. No evidence of suicide or homicide ideation. No evidence of hallucinations or delusions. He was oriented to person, place, and time and his insight and judgment do appear intact considering his age.
Vitals: Height 45-3/4 inches, 5th to 10th percentile. Weight is 44 pounds, 10th percentile.
Testing: His teacher filled out a child behavior checklist. On this form, she notes that he is delayed in reading but is advanced in science and social studies and is at grade level in all of his other subjects. She notes that he gets a half-hour day of tutoring; otherwise, he is in a regular first grade classroom. She notes that achievement tests were done in March, but we have not gotten the scores
back. No IQ test is on record. She notes that he has difficulty seeing and does wear glasses. She notes that he has a lot of difficulty staying on task, and she is aware of his issues related to his mother. She says "I also worry about him going to live with his mother; I think he would lose all the security he has now." She goes on to say that he has "some of the best manners I have ever observed in a first grader. He is always respectful," and she notes that he is highly knowledgeable about many different topics. On the checklist, she notes that he has difficulty finishing his work, that he tends to argue, and has trouble concentrating somewhat or some of the time. She reports that he is not hyperactive, but that he does fidget. She says "Dan fidgets with his pencil often pretending it is an airplane." He is strongly prone to get daydreaming getting lost in his thoughts. He is fearful of fire drills. His work tends to be messy. He has some difficulty making speech sounds. Sometimes, he is stubborn, sometimes has a hot temper, and has some worrying problems; otherwise, the checklist is unremarkable. Grandmother filled out the same form, parents' version, and she

notes problems with arguing, concentration, restlessness, and in addition notes his problems with encopresis and enuresis. As noted in the history, not eating well and being thin and slow growth, hearing sounds or voices, it turns out that these are based on fears and not full-blown hallucinations. Nervous, high strong, or tense almost all the time, nightmares on a regular basis, too fearful and anxious, mood instability with screaming and showing off and temper outbursts and unhappy depressed spells, and lots of worries. Trouble sleeping is a prominent problem as noted in the history.

Lab: I do not have any copies of lab tests.

Assessment: Dan comes to my clinic with a prior diagnosis of attention deficit hyperactivity disorder and a question about anxiety symptoms. I find that he meets DSM-IV criteria for attention deficit hyperactivity disorder in addition to posttraumatic stress disorder. In addition, there are some mood issues and insomnia problems that strike me as a bit excessive for posttraumatic stress disorder, and he has a strong family history of mood problems, in particular several individuals are affected by bipolar disorder suggesting that there may be some genetic underpinnings for some of his mood and insomnia problems. Grandmother is quite clear that she does not think that there is any way that mother can be successfully involved in this boy's life, and Dan indicates that he does not want involvement with mother either. Unfortunately, at least in grandmother's view, the judge has not responded by terminating parental rights, and so, we have that hanging over Dan on a daily basis. We discussed medication options. I will focus my efforts on medication because he already has counselors and because he lives so far away from my clinic. We will make the switch to the longer-acting Focalin, and we will start a trial of Seroquel to treat insomnia and mood instability, and hopefully, his anxiety and posttraumatic symptoms as well. Clonidine was considered but rejected because its effects are only for few hours at night and unlikely to have much benefit during the daytime hours. We carefully discussed the risks of the use of Seroquel and Focalin, particularly some of the unknown issues in people of all ages and particularly in younger children. Grandmother indicated that she understood and was willing to proceed with the plan as listed below.

DSM-IV:

I: Posttraumatic stress disorder; Attention deficit hyperactivity disorder; Mood disorder, not otherwise specified; Parent-child relationship problem.

II: No diagnosis.

III: History of recurrent otitis media and tympanostomy tubes on two different occasions, situational encopresis and enuresis, and vision problems and eyeglasses.

Recommendations and Plan:

1. Switch the Focalin to a 10 mg XR capsule given once everyday in the morning, stop the regular Focalin. A prescription was written for 30 pills, no refill.
2. Start Seroquel 12.5 mg at bedtime for 5 nights, then increase it to 25 mg if he has not had good success. While we are waiting for the results of Seroquel, they can continue to give melatonin, but I have encouraged them to cut back on the dose and possibly stop it if he is able to sleep well with Seroquel.
3. Ongoing counseling is essential, and he is referred back to his current providers for that to do that work.
4. In my opinion, a decision should be made regarding parental rights, so that Dan can have some predictability and a sense of safety in his life. Based on the information available to me today, I believe it is prudent to have supervision of any visits or contact between Dan and his mother.
5. Dan's grandmother might benefit from further counseling and/or psychiatric evaluation to help with her grief and anxiety and irritability symptoms.

Jeffrey S. Green, M.D.

JSG/SAY/SUK
D: 05/18/2007
T: 05/19/2007

cc: Dan's grandparents

BRIDGER CHILD AND ADOLESCENT PSYCHIATRY, P.C.
931 Highland Blvd., Suite 3340
Bozeman, MT 59715
406-586-9735 Fax-4713

NAME: Dan Pryor

DOB: 11/01/1999

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MARY L.QUINT, LCSW. ACSW, BCD
600 Central Ave, Ste. 418
Great Falls, MT 59401
(406) 452-1171

RE: Daniel Pryor
DOB: November 1, 1999

August 8, 2005

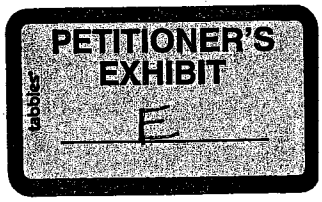
To Whom This May Concern:

I have been treating Daniel since April 14, 2005. I have diagnosed Daniel with the following:

DSM IV TR, Axis I: 309.81 Posttraumatic Stress Disorder (PTSD), Chronic
R/O 314.00 Attention Deficit/Hyperactivity Disorder, Combined Type
V62.82 Bereavement
Axis II: V71.09, No Diagnosis
Axis III: Otitis Media by history
Axis IV: Death of father; Custody dispute between mother/grandparents
Axis V: Current GAF: 54

Identifying Data:
Daniel is a 5 and a half year old boy who lives partially with his parental grandparents and his mother on a half week basis. During therapy, Daniel has discussed the loss of his father which occurred September 11, 2004. He has shown both aggression and grief in play therapy, especially while playing in the sand box. Daniel is very anxious and stutters occasionally. He was very clingy initially, and would impulsively run to the waiting room to see if his grandmother was still there. He does have difficulty with ending a session and has been aggressive when he had to leave. Daniel does have PTSD, but some of the symptoms found in children with PTSD are also exhibited by children with Attention Deficit Disorder, or ADHD and therefore he should be tested. Daniel's grandmother has scheduled Daniel to see Dr. White, a pediatrician skilled in diagnosing and treating ADHD. It is likely Daniel has ADHD because it was reported his father also was diagnosed with ADHD as a child.

Recommendations:
Daniel should have his mother in his life but he needs consistency. He needs to know that he will be picked up at a certain time and that his life is predictable and safe. Children that are inattentive and impulsive such as Daniel is, benefit from a structured environment and a small classroom. The guardian, school officials, and therapist should work closely together to help with behavior problems and social deficits. Daniel should meet with the school and his teacher should be briefed prior to Daniel starting school. Daniel suffers from low self- esteem and should be comfortable with his academic environment. Daniel's mother or grandparents should keep in contact with the school on a daily basis the first month of school because I feel this will be a very difficult transition for Daniel and it's important he receives a lot of encouragement and praise. His exposure to television should be closely monitored because he often has nightmares related to scary movies he has watched. I highly recommend Daniel should be seen by Dr White and prescribed medications to help him stay on task, if she feels it is a medical necessity. Daniel's grandparents and mother should attend mediation to learn to work together for Daniel's sake; I do believe that some of this chaos is contributing to Daniel's emotional problems and appears to be traumatic for him. I have never heard from Daniel's mother, Jennifer, but I am willing to work with her. Daniel should receive therapy at least once a week to learn social skills, deal with his father's death, and to help with his emotional problems; ie, oppositional behavior, obsessing on death, impulsivity, and inability to focus and follow



directions, which are all vital for his success in school.

Please feel free to contact me at 452-1171 if additional information is requested. Thanks.

Mary L. Quint

MARY L. QUINT
Licensed Clinical Social Worker